Department of Veterans Affairs **VHA DIRECTIVE 2004-061**
Veterans Health Administration
Washington, DC 20420 **October 29, 2004**

VETERANS RURAL ACCESS HOSPITALS

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes policy defining the clinical and operational characteristics of small and rural facilities within VHA. ***NOTE:*** *Each of these newly defined facilities will be referred to as a Veterans Rural Access Hospital (VRAH); however, the facilities are not to change their official name.*

2. BACKGROUND

a. The Capital Asset Realignment for Enhanced Services (CARES) Commission Report to the Secretary of Veterans Affairs, dated February 2004, recommended in Chapter 3 that the Department of Veterans Affairs (VA) should establish a clear definition and policy on the Critical Access Hospital (CAH) designation prior to making decisions on the use of this designation. In response to this recommendation, the Deputy Under Secretary for Health and the Deputy Under Secretary for Health for Operations and Management established a task force to define guidance on the appropriate scope of services that should be provided at small and rural facilities within VHA, and to determine an appropriate designation for these facilities. In identifying the complexities of the scope of services, consideration of surgical procedures, supportive infrastructure, post-operative and intensive care, patient safety, and outcomes were considered.

b. A VRAH is a VHA facility providing acute inpatient care in a rural or small urban market in which access to health care is limited. The market area cannot support more than forty beds. The facility is limited to not more than twenty-five acute medical and/or surgical beds. Such facilities must be part of a network of health care that provides an established referral system for tertiary or other specialized care not available at the rural facility. The facility should be part of a system of primary health care (such as a network of Community-Based Outpatient Clinics (CBOCs)). The underlying principle is that the facility must be a critical component of providing access to timely, appropriate, and cost-effective health care for the veteran population served. The activation and operation of a VRAH will be similar to that of any other VHA hospital. The designation of a facility as a VRAH will not remove or diminish that facility's responsibility in meeting appropriate VHA requirements, directives, guidance, etc.

c. The policy and guidelines established in this VHA Directive will be used to complete studies of specific facilities identified in the Secretary's CARES Decision of May 2004. These studies will be completed by the Veterans Integrated Service Networks (VISNs) in conjunction with the National Director of Surgical Service by December 2004, and the results will be included in the Fiscal Year (FY) 2005 strategic planning cycle. Sharing this VRAH Directive with stakeholders is encouraged, as VA seeks further comments as facilities are studied.

3. POLICY: It is VHA policy to determine and monitor the scope of services to be performed at its VRAHs (specifically, those procedures that are complex in nature), and to establish parameters for how these facilities need to prepare to meet future challenges.

THIS VHA DIRECTIVE EXPIRES OCTOBER 31, 2009

4. ACTION

a. **Principles.** The following principles are established to ensure that the scope of services provided by VRAHs is sufficiently restricted to ensure acceptable safety, effectiveness, and efficiency.

(1) VRAHs are held to the same external accreditation standards (Joint Commission on Accreditation of Healthcare Organizations (JCAHO); College of American Pathologists (CAP); the Rehabilitation Accreditation Commission, formerly the Commission on Accreditation of Rehabilitation Facilities (CARF); Nuclear Regulatory Commission (NRC); Blood Bank; etc.) as other VHA facilities.

(2) VRAHs must meet the same internal quality measures as any other VHA facility, i.e., performance measures, the National Surgical Quality Improvement Programs (NSQIP), credentialing and privileging requirements, utilization management, risk management, patient safety programs goals, and other VA quality, safety, and cost-effectiveness measures.

(3) Average lengths of stay are determined by the use of InterQual Standards for each patient admitted to hospital care. ***NOTE:*** *VISN offices are responsible for providing oversight of the lengths of stay for admissions to VRAHs.*

(4) Given the inherent risk of low numbers of procedures and the known volume-outcome relationship in predicting quality in most situations, a list has been established of complicated, resource intensive, high-risk, specialized surgical and medical procedures that are not to be performed at VRAHs (see subpars. 4b(1)(b), 4b(2)(a), and 4b(2)(b)). ***NOTE:*** *VRAHs may seek permission to perform procedures on the excluded list through a formal approval process (see subpar. 4b(3).*

(5) Credentialing and privileging of clinical providers, including privileges for invasive procedures, remain the responsibility of the facility's medical staff. Privileges for surgical or other invasive procedures need to explicitly address whether the expected volume of procedures is sufficient to maintain the operative skills of the physician and support staff. Privileges granted must take into consideration the VRAH's capabilities to support those granted privileges. If a facility does not have adequate support staff, equipment, etc., the privileges must not be granted. ***NOTE:*** *VISN offices are responsible for providing oversight of the Credentialing and Privileging process in these VRAHs.*

(6) The term, Intensive Care Unit (ICU) beds, will not be used within VRAHs, unless all clinical expertise for operating ICU beds is present. VRAHs must provide ICU care at Level 4 or higher in order to be considered a VRAH and continue to provide inpatient surgery. Beds in VRAHs that cannot meet the Level 4 criteria may be more appropriately named observation beds, monitored beds, or progressive beds. The four levels for ICUs recognized within the Veterans Health Care System and the criteria for each level are detailed in Attachment A. VRAHs not at the Level 4 criteria are not to operate ICU beds until action is taken to reach that level. Length of Stay is not a determining factor as to which level is appropriate for VRAH ICUs.

(7) Emergency services must be provided to patients accessing the facility to the extent of the facility's capability to care for those patients. VRAHs must be part of an established, effective referral network. Facilities must have in place formal policies and procedures for timely referral and transfer of patients requiring care beyond the facilities' capabilities. This means when a patient requires transfer to a more complex level of health care, resources are available within VA, or through referral in the community, to facilitate the transfer in an appropriate amount of time.

(8) Efficiency is a fundamental factor in determining which services will be provided by VRAHs. If services can be more effectively and efficiently provided by another VA facility or non-VA source, those services should not be provided in the VRAH.

(9) Because of their rural nature, VRAHs may have difficulty in attracting sub-specialists in various health care professions to provide consultations to veteran patients in both inpatient and ambulatory care settings. Telehealth is a way in which such expertise may be obtained. It is therefore appropriate that the VRAH utilize telehealth to enhance health care decision-making and avoid unnecessary travel of veteran patients by improving local access to specialist expertise.

b. **Surgical and Medical Procedures Appropriate Within a VRAH.** Decisions to undertake certain surgical and medical procedures need to be locally determined and will vary depending upon the skills of the surgeons and medical practitioners; availability of ancillary support, such as laboratory, x-ray, blood bank, skills of nursing staff, level of anesthesiology services, recovery; ICU capability, and the ability to respond to emergency situations that may arise during the course of performing certain procedures. These factors must be a part of the provider privileging process. ***NOTE:*** *The capability of a VRAH to provide surgical procedures and complex medical procedures varies from facility to facility. One definition of surgical and/or medical capability will not suffice to address the needs of all facilities offering these services.*

(1) **Surgical Services.** For a meaningful NSQIP analysis, 300 surgical cases over a 3-year period are needed. Therefore, a surgical volume of 125-150 major cases a year is established as a threshold that permits analysis of risk-adjusted mortality and morbidity. VRAHs doing less than this volume of major cases on an annual basis need to be assessed locally to determine whether intra- or inter-VISN referrals are a more appropriate alternative for providing surgical care.

(a) If a decision is made within the VISN and at the local level to provide Surgical Services at a VRAH, General Surgery, Orthopedic Surgery, and Urological Surgery may be performed within the capability of the surgeon and the facility's ability to support the surgeon with appropriate staff and services.

(b) Certain surgical procedures and medical specialties are not to be performed at a VRAH. Those are:

1. Cardiac Surgery

2. Neurosurgery

3. Vascular Surgery

4. Complex Oncology Surgery

5. Complex and/or Invasive Cardiology Procedures

6. Hepatic Resections

7. Complex Colorectal Surgery, and

8. Complex Endoscopic and Gastrointestinal Procedures

(2) **Medical Services.** The following are examples of procedures that are appropriate for inclusion in the spectrum of services in a VRAH. ***NOTE:*** *These lists are not all inclusive and additional procedures may be performed based upon the skills of the practitioner, the support services, and the staff available within the facility.*

(a) Gastrointestinal

1. Esophagogastroduodenoscopy

2. Esophageal dilatation of uncomplicated esophageal strictures (bougienage, or wire-guided dilators)

3. Esophageal variceal banding

4. Colonoscopy

5. Polypectomy

6. Mucosal biopsy

7. Percutaneous liver biopsy

8. Heater probe electrocoagulation of bleeding lesions, and

9. Flexible sigmoidoscopy

(b) Cardiology

1. Insertion of central intravenous (IV) catheters

2. Electrocardiogram (EKG)

3. Fibrinolytic administration

4. Echocardiogram

5. Exercise and/or pharmacologic stress testing

6. Nuclear stress testing

7. Pericardiocentesis

8. Thoracentesis

9. Event monitor or Holter monitor

10. Temporary pacemaker insertion

11. Right heart catheterization

12. Direct Current Cardioversion

13. Initial evaluation and stabilization of Acute Coronary Syndrome, with plans made for transfer to a referral facility for continued evaluation and recommendations for long-term management.

14. Initial evaluation and management of cardiac rhythm disorders with plans made for transfer to a referral facility for continued evaluation and recommendations for long-term management.

(3) **Responsibilities**

(a) Oversight. The oversight and monitoring of Surgical Programs and complex medical procedures in VRAHs are the responsibility of the VISN Director in conjunction with the National Director of Surgical Services. VISN Directors must annually review the VRAHs within the VISN to ensure that there is compliance with the limitations established in this document. VA Central Office Surgical Service will monitor the Surgical Programs at VRAHs through the use of Annual Surgical Reports and NSQIP Reports.

(b) Exemptions. VRAHs may request exceptions to these limitations. Requests for exceptions must be submitted to the National Director of Surgical Services, after concurrence from the appropriate VISN Director. The request must include detailed documentation of the facility's capability to provide the requested surgical and/or medical procedures. This will include sufficient documentation of the capability of the facility practitioner(s), and the facility's capability to support the services being requested.

5. REFERENCES

a. Secretary of Veterans Affairs CARES Decision, May 2004.

b. CARES Commission Report to the Secretary of Veterans Affairs, February 2004.

6. FOLLOW-UP RESPONSIBILITY: The Office of the Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this Directive. Questions may be referred to Office of Strategic Initiatives (202) 273-8325**.**

7. RECISSIONS: None. This VHA Directive expires October 31, 2009.

Jonathan B. Perlin, MD, PhD, MSHA, FACP
Acting Under Secretary for Health

DISTRIBUTION: CO: E-mailed 11/04/2004
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 11/04/2004